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I. TASK FORCE CREATION AND PREPARATION

The principal reason for creation of the Mayor's Healthcare Access Task Force was to address the more than 450,000 uninsured Miami-Dade County residents.

To offer a framework for developing viable solutions to this growing crisis, Mayor Alex Penelas held a meeting called the Health Care Access Initiative on February 15th, 2002. This event, held at Miami-Dade Community College Wolfson Campus, brought together over 160 people from the community and resulted in a formal "Call to Action" by the Mayor.

The purpose of this daylong Initiative was to bring the public and private sectors together to identify barriers that inhibit access to healthcare for Miami-Dade County's uninsured population and formulate recommendations to address the problem.

The charge for this Initiative was "to ensure that residents in Miami-Dade County have access to quality, convenient and affordable healthcare coverage through governmental and private partnerships and public awareness of available and new programs."

Health care leaders and participants voted on different issues and identified priorities for the community in the following areas:

1) Expanding Eligibility
2) Outreach and Education
3) Public/Private Partnerships
4) Governance

At the Initiative, Mayor Alex Penelas announced the formation of the Healthcare Access Task Force to implement and shape the priorities developed by Initiative participants. Mayor Penelas appointed three Co-Chairs for the Task Force: Steven Marcus, Ed.D.; Foundation Co-Chair, James Bridges, M.D., Medical Co-Chair; and Carlos Saladrigas, Private Sector Co-Chair. The Mayor later appointed 52 members to the Task Force from both the public and private sectors in the following categories: educational, local, state and federal legislative bodies; behavioral health care; health care services delivery system; pharmaceutical; advocacy; faith-based organizations; health care planning; legal; and health care consumers.

A. Organization of Task Force

Beginning in March 2002, the Task Force held two organizational meetings to launch its work activity. At the inaugural meeting, Mayor Alex Penelas stated the mission of the task force is to "provide accessible, quality, convenient and affordable healthcare and develop a comprehensive healthcare plan for residents in Miami-Dade County." He charged the Task Force to create a healthcare plan that involves public/private partnerships in the development of the plan, which may include additional funding and

more/expanded health programs for the needy. Leading concerns centered on a) the need to educate residents on how to access existing programs and services; b) how to improve the health status among children; and c) ways to provide healthcare coverage to the working uninsured and immigrant communities. The group would have one year to accomplish its task.

As a way of outlining the scope of work ahead, the Task Force Co-chairs introduced a work plan for the group to follow over the next year. First at hand, was for the Task Force to develop a set of organizational procedures to guide its work. This would be followed by an orientation series to provide background information to all members and afford them with a common base of reference. Third, the group would review the existing system of care, and familiarize themselves with the funding streams from the national, state and local levels that support health care delivery in Miami-Dade County.

Some of the other important work activities accomplished during the initial organizational phase included briefings on the Sunshine Law – Public Meetings/Public Records Requirements and Conflicts of Interest by Gene Shy, legal counsel; a briefing on the report of the Mayor's Healthcare Initiative Summary Report; identification of guiding principles for the meetings, such as quorum requirements (21 members), the maximum allowable unexcused absences (2), provision for alternates designations (for elected officials only); and retaining health consultants for the orientation phase.

Once the Task Force members were given the appropriate reference materials, working from a common database of information, the group would begin the formation of focused committees to analyze and engage in solution-oriented deliberations. Members would be asked to serve on the committees to develop alternative service delivery and financing options as well as identify how to reach the populations identified. By mid-March, a Final Plan would be issued to represent the consensus findings, priorities and strategies of the Task Force. (See Appendix A: Work Plan).

B. Orientation of Task Force

Summary of Previous Health Plans

To gain a better understanding of the previous and current health planning efforts, the Task Force examined, in summary form, 14 comprehensive health plans in the community that were developed over the past 10 years.   The 40-page document on <u>Historical and Contemporary Plans and Related Documents</u> was presented at the May 30th meeting and offered highlights from reports such as the Indigent Health Care Task Force Report, the Miami Action Plan for Access to Health Care, the Jackson Health System Strategic Plan, the Comprehensive Health and Social Services Master Plan 2001-2004, the Comprehensive Health Plan for Miami-Dade and Monroe Counties, 2000-2002, and the Dade County Health Care Five Year Plan and Information Update, to name a few.

These documents were selected based on their relevance to the Task Force's mission and their specific focus on Miami-Dade County. The reports address the needs and issues that have a major impact on access to critical health care services for the uninsured and underinsured populations. Moreover, these documents offer a basis for understanding the recurring themes that hinder the existing service delivery system from operating in a manner that serves the most people, at the highest benefit, and at the most appropriate level of care. Key to the process was the belief that it is possible to "get more people to better health, for less cost per person" (Baumgartner, February 2002).

The selected reports were organized as follows: three Indigent Care Reports, five Comprehensive Health Plans, four Community Health Profiles and two studies on Financing Uninsured Health Care. A companion set of matrices were also developed for the purpose of cross comparison analyses. The purpose of the report was to summarize their findings and recommendations for planning purposes within the context of historical and ongoing issues of community concern.

Key issues identified across the spectrum of preceding studies and reports[1] are to:

- Eliminate barriers to care (e.g., lack of transportation; hours of operation; eligibility and enrollment issues; cultural sensitivity; lack of knowledge of available programs);
- Promote inter-organizational collaborations among healthcare and social service providers; planning entities; and public and private sectors;
- Address finance and resource development for increased funding; innovative healthcare models; preventive and health education; patient cost/Medicaid buy-in;
- Expand education and outreach efforts to enroll eligibles into existing public health insurance programs; reduce the inappropriate utilization of emergency rooms; address needs of special population groups, including the elderly; and foster preventive care;
- Integrate data systems and promote information sharing;
- Explore patient choice options through continued decentralization of health and medical care, including primary care and mental health and substance abuse services; and
- Explore and evaluate best practice models for health insurance; mental health coverage; immigrants; employees; and persons with chronic illnesses.

Some of the recommendations identified in the historical documents have been addressed on an incremental basis, e.g., TrustCare Program, and modest reforms have been achieved, e.g. creation of the Miami-Dade County Health Policy Authority. The community should be recognized for its accomplishments. Yet, even though the key findings and recommendations were thorough and feasible, on the major health policy issues and system wide solutions, most of the recommendations of these plans have unfortunately not been implemented. These issues encompass recommendations such as

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[1] Summary of Historical and Contemporary Plans and Related Documents: Intent, Salient Findings and Recommendations, Health Council of South Florida, May 30, 2002.

expanding coverage, eliminating non-insurance barriers, policy planning and sustainability (MAP) and improving access to services, assuring financial viability, strengthening organizational effectiveness (Jackson Health System Strategic Plan).

Definition of the Problem

The needed structural and policy reforms persist today. Based on prior studies and observations in the field, the current approaches to health care planning, delivery and evaluation are fragmented, lack coordination, are not sufficiently integrated and may not be properly structured to offer appropriate oversight and accountability of publicly financed health care.

During a review of the Definition of the Problem, Task Force members expressed that community leaders working toward improving access to care should address the needs of the most vulnerable population groups which include young adults (18-34 year olds); males; minorities; residents living under 200% of the federal poverty level; the working uninsured with an emphasis on small business employers and their employees; low-income elders; and individuals suffering from substance abuse and mental health related illnesses.

Populations Most Vulnerable to Lacking Health Insurance Access

One important way to promote access is to provide healthcare coverage. However, according to a statewide study on health insurance, Miami-Dade County has one of the highest percentages of non-elderly uninsured in the state and holds the highest rate for any urban county in Florida, surpassing Broward, Palm Beach, Hillsborough, and Pinellas Counties by 60%. More severely affected neighborhoods can be identified by utilizing zip code level data where rates can go as high as 41.5% in some communities. (Overtown, zip code 33136).

The following figures present a breakdown of Miami-Dade County's uninsured by a variety of elements, including age group, race and ethnicity, and employment status:

Observations:

- 18-34 year olds have the highest rates for uninsured status.
- Minorities are at least 2.5 to 4 times more likely to be uninsured than White Non-Hispanics. According to a recent report by the Institute of Medicine, racial and ethnic minorities tend to receive lower quality healthcare alternatives for services such as cancer treatments, cardiac medications, bypass surgery, HIV treatments, and kidney dialysis.[2]
- Those not getting a high school diploma have a 1 in 2 chance of being uninsured.
- More than two-thirds (67.8%) of the uninsured live at or under 200% FPL.

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[2] The Healthcare Divide, Black Enterprise Magazine, July 2002.

- Persons employed in small businesses (1-24 employees) comprise nearly one-quarter or 104,000 of the uninsured. Florida is a state of small businesses – two-thirds of the state's 600,000 businesses have 5 or fewer employees.[3]
- Just under half (46.4%) of the uninsured are working adults (209,000) either full-time (158,000) or part-time (51,000).

Public Hearing

Many historical and contemporary reports have documented the community's difficulties with obtaining healthcare coverage and accessing health services. To further explore these issues with the community, Miami-Dade Community College hosted a public hearing for the Mayor's Healthcare Access Initiative on June 20, 2002. This public meeting provided further evidence regarding the multi-dimensional aspects of this pressing issue. The underlying themes centered on issues pertaining to children, immigrants, the working uninsured, and individuals suffering from mental health conditions.

Some of the key issues voiced by community members and advocates were:

- Parents and the public at large lack knowledge of available programs and services.
- Public program eligibility issues (e.g., 5 year resident requirement) restrict access for children and immigrants, in particular.
- Language and transportation barriers limit access to care.
- The location of primary care sites limits access to care.
- Small business employers do not always offer coverage and premiums can be high even with employer assistance.
- Insurance coverage is oftentimes perceived as a low priority.
- Pre-existing conditions (both chronic and catastrophic, e.g., diabetes, cancer) preclude consideration for coverage.
- Eligibility for public assistance programs such as Medicaid generally extends to parents with children. **Illustration:** A parent indicated that she lost coverage once her children became adults although she had a life-threatening condition and was ineligible for private health insurance coverage.
- Services are not appropriately case managed.
- Access to modern medications is limited.
- The county's jail has become the largest public psychiatric hospital in Florida.

Possible solutions derived from the hearing included:

- The TrustCare Program should be countywide.
- An insurance model similar to KidCare for adults between 19-63 years of age is needed.
- An integrated computer tracking system should be instituted.

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[3] Cost Crisis, Florida Trend Magazine, June 2002.

Review of Best Practices

The Task Force then examined a number of Best Practices around the State and the nation (in Indiana, Massachusetts, Michigan, Pennsylvania, Texas, and Wisconsin). Brief descriptions of the community collaborations for access to healthcare were distributed. These models were of great interest because they showcased actual experiences and real achievements in communities across the country that have continued to have an impact on their local populations.

According to Phyllis Busansky, and Dr. Eric Baumgartner, project consultants, each of the models demonstrates leadership, community partnerships, leveraging of resources and the commitment to action in order to deliver better health for more people in a more efficient and effective way. Where the brief abstracts presented were limited in detail, they did provide a chance to understand the major strategies, operations, achievements, and resources in the partnerships that had been developed.

Some of the lessons learned were to:

- Use information technology to support system and track activity
- Emphasize quality, accessibility and acceptability
- Leverage existing resources in the community
- Realize dramatic cost savings through better management of risk
- Tremendous community and political will can be rallied around health care
- Applying sound managed care systems works in community settings

Ms. Busansky described what successful communities run on: leadership across organizations and sectors; shared vision/principles; inclusiveness; enlightened self-interest; reciprocal accountability; requests and offers; and smart alignment of resources. The latter encompasses leveraging small amounts of local resources, acquiring new resources from non-participating sectors, and drawing down from resources outside the local community, such as from national, state and private grant sources, including marketplace sources. There must be an organizing platform that provides focus for on-going cooperation, development and administration of the initiative. Someone must be there to manage the program.

Ms. Busansky invited the group to consider the initiatives presented as models to prompt the Task Force's own leadership thinking about innovations in Miami-Dade County that can better serve the unmet healthcare needs. Another community's strategies would not most likely be adopted as is, but rather their strategies could suggest creative ways that might be modified, improved or combined in order to meet the group's community's needs in its own way.

Inventory of Resources and Service Providers

The Task Force proceeded to engage in a comprehensive review of the existing resources and service providers in the community. The inventory highlighted the health system

strengths and limitations and provided a valuable foundation for the subsequent committee work that was undertaken.

Provider groups were inventoried and presented on maps for ease of reference and to visualize their coverage across the county. Providers inventoried included: hospitals, trauma centers and hospital emergency rooms, local public health department sites, Jackson Health System (JHS) primary care centers, Federally Qualified Health Centers (FQHCs), other local clinics and health centers, school based health programs, Medicaid physician offices, MediPass physician offices, and JHS correctional health services clinics. Both health system strengths and limitations were considered.

To further enhance its understanding of the prevailing issues, the Task Force listened to presentations from several local providers and associations.

Matrix of Current Funding and Service Levels

Fiscal data at the federal, state and county levels were requested from a wide array of entities between April and September 2002: The Agency for Health Care Administration, Area Health Education Centers, Dade Community Foundation, Florida Department of Children and Families, Florida Department of Health, Health Foundation of South Florida, Jackson Memorial Hospital, Maimi-Dade Homeless Trust, the United States Senate and the United Way, among others.

Based on the data collected, a summary of public and local charities funding streams for health care was created. While not a complete picture, the report provides a synopsis of the major funding streams flowing into Miami-Dade County and the state as a whole for health care related initiatives and services. According to the information shown, there are nearly 565 million dollars allocated to Miami-Dade County from all revenue sources in FY 2000-2001. In Florida, the amount was 7.1 billion dollars.

The largest share of the County's allocations ($259.2M or 45.9%) is made-up by state funding sources such as the Disproportionate Share Hospital Program ($87.5M); Florida Department of Children and Families ($66.3M); Florida Department of Elder Affairs ($41.2M); and the Ryan White Title II AIDS programs ($25.3M). (It should be noted that some of these sources are pass-through agencies for federal funds.) The next largest share of 246.3 million dollars (43.6%) is from county sources, primarily the half penny sales tax ($234.2M). The Health Foundation leads the way for local private foundations allocations ($4.8M).

Clearly, this is a very large industry with significant funds being expended throughout Florida. The proportion of funding being spent on publicly financed healthcare in Miami-Dade also appears to be high, when compared to the respective proportion of the county's population to the state as a whole (22.6%, versus 14.1%, excluding Medicare funds). Direct draw downs from the federal government, on the other hand, seem insignificant and primarily directed to university systems at 59.2 million dollars countywide (less than 1% of Florida's total overall share at $6.1B statewide).

Charity Care Provision

A final component for the Task Force's plan development process was the challenging task of developing a consistent, streamlined and quantifiable overview of charity care in Miami-Dade County. This task involved conducting a survey of the existing provider community to determine the current provision of charity care countywide.

A total of 268 surveys (see Appendix for survey instrument) were sent to providers representing hospitals, behavioral health care providers (serving >500 persons), full service schools, community health centers and Medicaid physicians (serving ≥250 persons). The mailing list of providers was based on the document, An Inventory of Existing Community Resources and Services, created by the Health Council for the Task Force and from the databases of the Department of Children & Families and the Medicaid Office. Follow-up telephone calls were conducted and clarification of data requests was provided to participating organizations.

Survey Data

The information requested on the distributed survey (for calendar year 2001) included: total cost of charity care (participating hospitals were instructed to not include bad debt or contractual allowances), demographic patient data (age, race/ethnicity, and gender), number of visits, top 10 DRGs, top 10 diagnoses treated (non-hospital groups), funding source of charity care, and available requested data at the zip code level.

Charity Care Definition

For hospitals, the definition, as stated by Florida Statute #395.4001, was:

"*The portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal poverty level for a family of four be considered charity.*"

This definition was utilized due to its statutory existence and its familiarity to hospitals in assessing charity cost.

For other groups such as health centers, the definition was modified to accommodate the various sliding fee scale schedules and maximum allowable limits utilized by non-hospital groups:

"*The portion of reportable charges of which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 300 percent of the federal poverty level.*"

Survey Response

Surveys for a total of 70 facilities were returned reflecting a 26.1% response rate. However, higher responses were reflected among hospital facilities (65.6%, 21/32) and community health centers (63.5%, 33/52). Response rates from other groups (behavioral health care providers, Medicaid physicians, and full-services schools) ranged from 1.5% to 36.4%.

Data Limitations

The data presented were not inclusive of all healthcare entities in Miami-Dade County that provide charity care. The information reflected only the perspective of charity care provided among the major hospital providers (accounting for 76.6% of Miami-Dade County Hospital discharges) and community health centers. Information from other groups was not included due to their low response rate. Additional costs incurred by hospitals that have disproportionately high rates of Medicaid patients were not reported and included in the data analysis. Over counts may occur due to the lack of an integrated patient database, and provision of charity care by physicians was not captured.

Key Results

Based on collected information from participating hospitals for calendar year 2001, key results show:

- The highest charity patient admissions and outpatient visits were by patients living in zip codes 33012 (Hialeah), 33125 (Little Havana), 33127 (Little Haiti/Wynwood/Miami), 33135 (Little Havana), 33142 (Allapatah/Brownsville/Melrose/Liberty City), 33147 (Liberty City) and 33161 (North Miami/Biscayne Park/Biscayne Shores).
- Jackson Memorial Hospital (61,969 charity admissions and outpatient visits, 69.0%) and Anne Bates Leach Hospital (19,129 charity admissions and outpatient visits, 21.3%) reported the highest number of charity admissions and outpatient visits.
- Jackson Memorial Hospital incurred the highest amount of charity cost at $378,950,916 or 77.8% of the total sample's (20 hospitals) reported cost at $486,868,719.
- With regards to cost associated with charity patients utilizing the emergency room and not admitted, Jackson Memorial Hospital incurred the highest cost at $2,446,091 (33.8%) followed by Baptist Hospital ($868,508, 12.0%) and Mercy Hospital ($764,364, 10.5%).
- With regards to the source of underwriting charity care cost, all hospitals reported utilizing operating revenue. Jackson Memorial Hospital also utilized some portions of its funding from the half penny surtax and Anne Bates Leach Eye Hospital received partial support ($2.4M) from the Public Health Trust (PHT) for providing care to indigent patients referred from the PHT.

Possible areas for future studies include 1) identifying high risk charity patients and exploring alternative health care delivery options; and 2) researching substance and alcohol abuse, as well as mental health issues for charity patients entering the emergency room.

Based on collected information from participating health centers for calendar year 2001, results show:

- The highest charity patient visits in the reported sample were by patients living in zip codes 33127 (Little Haiti/Wynwood/Miami), 33137 (Little Haiti/Morningside/Wynwood/Miami), 33138 (Miami Shores/El Portal/Little Haiti/Miami), 33142 (Allapatah/ Brownsville/ Melrose/Liberty City), 33147 (Liberty City) and 33150 (Miami Shores/El Portal/Miami).
- Economic Opportunity Family Health Center facilities collectively reported the highest number (118,569, 29.5%) of charity patient visits followed by Community Health of South Dade facilities (73,144, 18.2%) and Miami Beach Community Health Center facilities (68,384, 17.0%).
- Miami Beach Community Health Center facilities incurred the highest charity cost at $12,419,123 or 38.0% of the sample's (27 facilities) total reported cost at $32,674,973. Community Health of South Dade facilities had the second highest charity care cost at $6,938,757.
- Most (96.6%) of the participating community health center facilities reported utilizing federal, state and/or local funding to underwrite charity care costs. Funding from the Public Health Trust is cited by three entities (Community Health of South Dade, Inc., Jackson Health System, and Miami Beach Community Health Center) which collectively account for 16 facilities and 3 school programs.

Possible areas for future studies within the charity patient population include 1) developing strategies for increasing hypertension and diabetes awareness; and 2) identifying and replicating best practices for increasing maternal and child health screenings.